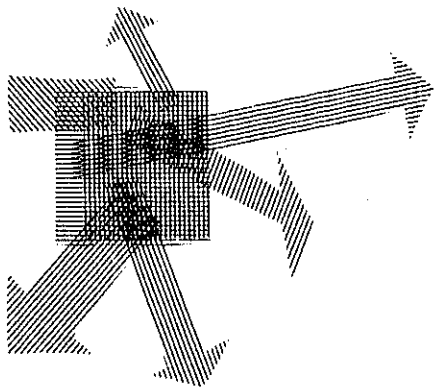
Facts and Trends on...

HOSPITAL Outpatient Services



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This is the third in a series of publications on Hospital Outpatient Services. Volumes published previously include:

Hospital Outpatient Services: Selected References Annotated, Public Health Service Publication No. 930–G–7. Price 30 cents.

Hospital Outpatient Services: Guide to Surveying Clinic Procedures, Public Health Service Publication No. 930–C–4. Price 40 cents.

The above publications are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402, at the prices cited.

Additional volumes will appear at intervals.

HOSPITAL AND MEDICAL FACILITIES SERIES
(Under the Hill-Burton Program)
organization · administration

Facts and Trends on . . .

HOSPITAL Outpatient Services

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
Division of Hospital and Medical Facilities
Washington, D.C. 20201

Public Health Service Publication No. 930–C–6

June 1964

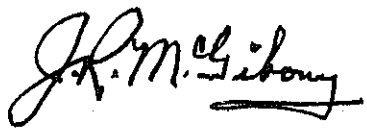
For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C., 20402 - Price 25 cents

Foreword

Physicians and other professional persons concerned with medical care and hospitals have become acutely aware of problems and patient loads in hospital outpatient services. Evaluation and planning in relation to such services must be a part of the approach to total community and hospital needs, problems, and resources. This approach will vary with the individual hospital and community. The degree to which problems will be resolved will, in large measure, depend upon the vision and interest of community leaders, planners, the medical staff, and hospital administration in meeting community needs.

This publication attempts to set forth various aspects of facts and trends to be used as guides and points of departure in studying and evaluating current problems and planning for outpatient services, an integral part of hospital and health services. It is one of a series relating to the subject. Previous publications include those listed on the inside front cover of this report as well as a brochure on organization of emergency services.

Mr. Robert J. Fitzsimmons, M.H.A., Hospital Administration Consultant in this Division, is largely responsible for compiling the data in this document.



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Introduction

Hospital outpatient services are being increasingly utilized by the population of practically all communities. This poses many problems related to community planning, clinical aspects, administration, personnel, staffing, finances, and provision of adequate space and equipment.

Good outpatient services, including emergency services, are essential elements in the contribution of hospitals to the total health picture of the community. In terms of diagnostic, preventive, and restorative health programs such services complement inpatient care as well as nonhospital services of the physician. They help the hospital to fulfill its role as the true focal point of community health, professional education, and service to humanity.

That more and more hospitals and their medical staffs are using hospital outpatient services to meet community needs and demands is exemplified by the tremendous increase in such services during the past few years. In 1948 about one-half of the non-Federal, short-term, general and specialty hospitals in this country reported having organized outpatient departments, handling three-fourths of the 43,431,338 patient visits to all outpatient facilities. From 1954 to 1958 outpatient visits increased 30 percent to 62 million, 34 million of which were general visits, 11 million unspecified, and 17 million emergency visits—an increase in the latter of 81 percent.

For 1962, the 5,291 hospitals reporting outpatient visits to the American Hospital Association recorded 99,332,469 such visits. In that year, 93.6 percent of the 5,049 short-term, general, and other special hospitals reported maintaining an emergency room, more than the number reporting obstetrical delivery rooms.

Hospital beds are not available in sufficient numbers, nor are they indicated, for all who need diagnostic and therapeutic services. Beds are costly to build and maintain, and it is economic waste to utilize inpatient care when outpatient services would suffice.

In 1962 average construction costs of Hill-Burton assisted hospitals was $22,000 per bed, excluding site, or $22.90 for each of the average 748 gross square feet per bed. Annual total operating costs per bed for all non-Federal, short-term, general hospitals in 1962 was $10,080, so that in 26 months this cost equaled that of construction.

In 1946 the average length of stay for inpatients in non-Federal, short-term, general hospitals was 9.1 days and the average hospital bill per admission was $85. In 1962 the average length of stay was reduced to 7.6 days, while the bill increased to $280 per admission. Costs per day in 1946 were $9.39; in 1962 this figure was $36.83. Continuing increases can be expected because of increased construction costs, wages and salaries, and the cost of food, supplies, and equipment.

A recent report of the U.S. Department of Health, Education, and Welfare, entitled *Goals for Community Services*,[1] discusses the effects of our rapidly changing way of life, focusing attention on problems being posed for American communities. Some of the major social and economic trends noted include:

- *A rapidly increasing population.* Each year the total increases by 3 million people—or the equivalent of a city nearly the size of Chicago.
- *The flight to metropolitan areas.* Two-thirds of the American people now live in metropolitan areas, and by 1980, 80 percent will.
- *Automation and technological progress.* Despite the expectation of continuing increases in national production, increased employment, industrial growth, and higher standards of living, many unskilled and semiskilled—and even some skilled jobs and occupations—will become obsolete, creating unemployment and problems of dependency.
- *Increasing numbers of young and of old people.* The increase in the younger and older age groups will intensify demands for health service since these two age groups are the heaviest per capita users of such services. This will also intensify economic problems, since the number of dependents per taxpayer will nearly double in the years ahead.

[1] U.S. Department of Health, Education, and Welfare. *Goals for Community Services.* Staff report from the Office of Assistant Secretary for Legislation. U.S. Government Printing Office, Washington, D.C. 1963. 20 pp.

• *Medical research.* The past two decades of growth and emphasis in medical research must be translated into a dramatic step-up in the quality, variety, and availability of comprehensive health services.

Hospitals and outpatient services are interwoven in the warp and woof of many of these problems and trends. Patterns of preventive and curative health services have reflected dynamic changes in methods, quantity, quality, and type of outpatient services being provided. For example, physicians are making increasing use of hospital outpatient facilities for services for their patients and for continuing education. Moreover, there are many indications that outpatient services, including emergency care, are no longer looked upon as "free care" for the unfortunate indigent. Individual patients and their families, agencies, and other third parties are demanding, receiving, and paying for the high quality of care deemed necessary and desirable by the public, physicians, and hospitals.

Insurance plans reflect this trend. In the United States, Blue Cross, which has more than doubled its membership since World War II, has in 10 years increased from 40 million to more than 56 million. Cases paid per 1,000 members for hospital inpatient care increased from 100 in 1947 to about 142 in 1962—less than 50 percent. Payment for outpatient care increased, in the same period, from about 12 to 65 per 1,000 members, more than 400 percent.

In Canada, payment by Blue Cross for inpatient care dropped from 114 in 1960 to 112 per 1,000 members in 1961. Payment for outpatient services has increased from 34 per 1,000 members in 1956 to 61 per 1,000 in 1962.

These are challenges which face planners for medical care, practicing physicians, and hospital administrators. Intensive thought and effort should be directed toward determining how the hospital, through its outpatient services, can best meet community needs for efficient, economical high-quality care.

Definitions and Terminology

Effective communication, a primary factor in every phase of successful planning, education, and administration, involves development, transmission, reception, translation, feedback, and interpretation.

Terms used in the field of institutional medical care have been subjected to more than ordinary abuse and misuse. This is particularly true for terms of reference pertaining to outpatient services. Variations are so many and diffuse as to almost produce chaos; certainly lack of compatibility in comparison of data.

How does one define Outpatient Services as opposed to Inpatient Services? From an organizational structure standpoint, the most generally accepted term is "Outpatient Department," a major department of the hospital, on a par with the departments of surgery, medicine, and others. Within this concept, since one cannot have a "department" within or inferior to a "department," the proper term for emergency services would be the "Emergency Care Unit" within an organized "Outpatient Department."

A discussion of definitions of specific terms follows:

OUTPATIENT DEPARTMENT

That section of the hospital with allotted physical facilities, regularly scheduled hours, and personnel in sufficient numbers assigned for established hours, to provide for care of patients who are not registered as inpatients while receiving physician, dentist, or allied services.

OUTPATIENT UNITS (CLINICS)

Those various units (excluding Adjunct Services units) of the Outpatient Department, responsible for general and specialty management of designated diagnostic and treatment procedures.

The following such Clinical Units may be included in a hospital's Outpatient Services:

Alcoholism
Amputee
Arthritic
Cardiovascular
Cerebral Palsy
Chest Diseases
Chronic Long-Term Disease
Crippled Children
Dental
Dermatology
Dietary-Nutrition
Ear, Nose, and Throat
Emergency
Endocrinological
Eye
Family Health
Gastroenterology
General Medicine
General Public Health
General Surgery
Geriatric
Gynecology
Health Education
Hearing
Home Care
Immunizations
Industrial Physical Examinations
Maternity
Metabolic
Multiple Sclerosis
Neurosurgery
Orthopedic Surgery
Other Communicable Diseases
Pediatric
Physical Medicine and Rehabilitation
Podiatry
Postnatal
Prenatal
Preschool Examinations
Prosthetic
Psychiatric
Psychological
Social Services
Speech
Tumor
Venereal Diseases
Well-Child

EMERGENCY SERVICES UNIT (CLINIC)

This unit, listed above, requires special mention. It is that unit (clinic) of the Outpatient Department where services are rendered to outpatients in the diagnosis or treatment of conditions determined clinically, or considered by the patient (or his representative), as requiring immediate physician, dentist, or allied services.

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ADJUNCT SERVICES UNITS

Those special diagnostic and therapeutic facilities and services established in the hospital for assisting in the determination and confirmation of the physician's or dentist's diagnosis, and/or the provision of treatment ordered by and under supervision of a physician or dentist.

The following adjunct services are often offered:

Anesthesiology
Blood Bank
Bone Bank
Diagnostic Radiology
Electrocardiology
Electroencephalography
Eye Bank
Inhalation Therapy
Laboratory
Pharmacy
Poison Center
Prosthetic
Radioactive Isotopes
Therapeutic Radiology
Tissue Bank

OUTPATIENT

A person given general or emergency diagnostic, therapeutic, or preventive health services provided through a hospital's facility or health program, and who, at the time, is not registered as an inpatient in the hospital. (The term includes persons given care through an organized home care program which is hospital based, coordinated and directed as an extension of its outpatient services.) There are three categories of outpatients:

1. GENERAL OUTPATIENT

A person given diagnostic or therapeutic services, on an outpatient basis, for other than an *emergency condition*, and who has not been directly referred for such services by his attending physician or dentist.

2. REFERRED OUTPATIENT

A person who is directly referred by his attending medical or dental practitioner for specific diagnostic or treatment procedures, *for other than an emergency condition*, and who will return to the practitioner for further care and disposition.

3. EMERGENCY OUTPATIENT

A person given outpatient emergency or accident care, for conditions determined clinically, or considered by the patient (or his representative), as requiring immediate physician, dentist, or allied services. (For basic statistical purposes, *referred emergency* cases are tabulated as Emergency Outpatients.)

Whether a patient is a true clinical emergency is an ex post facto determination, in the same way as, after examination, a patient might be labeled as blind, in shock, anemic, dead on arrival, or any other similar category.

From both an initial clinical and from a general administrative point of view, it matters little whether the term "emergency" is diagnosed by a physician or simply considered so by the patient. The fact remains that the hospital must provide space, equipment, supplies, nurses, attendants, clerical help, as well as physicians' services to give attention to and make some disposition of all those referred or presenting themselves.

OUTPATIENT VISIT

The arrival of a person at the Outpatient Department of the hospital to receive diagnostic or therapeutic services. Appropriate data are recorded for this outpatient. There are two types of visits:

1. NEW OUTPATIENT VISIT

An outpatient visit by a person who appears for the first time or within a specified period of time which is concurrent with reporting periods for inpatient admissions.

2. REPEAT OUTPATIENT VISIT

An outpatient visit by a person who appears within a specified period of time subsequent to a new outpatient visit.

AMBULATORY

This means "able to walk" and applies to both inpatients as well as outpatients, and should not be used as a synonym for the latter. Some inpatients are ambulatory; not all outpatients are ambulatory.

UNIT OF SERVICE

A measurable part of the volume of work or services produced or rendered in diagnostic and therapeutic facilities of the hospital expressed in terms of time and/or quantity.

Suggested Units of Service in activities directly concerned with outpatient care are in the following listing:

Activity	Unit of Service
Ambulance Service	Number of trips and calls made
Anesthesiology	(a) Number of patients served (b) Each half hour of use
Basal Metabolism	Each test
Blood Bank (Blood transfusion service).	(a) Each 500 cc -unit of whole blood or plasma issued (b) Number of blood groupings (c) Number of cross agglutinations (d) Number of Rh typings
Bone Bank	Each item furnished
Electrocardiology	Each electrocardiogram
Electroencephalography	Each electroencephalogram
Emergency Operating Room(s).	(a) Each hour of use (b) Each operation
Eye Bank	Each item furnished
General Examination	Each quarter hour of service
Immunization	Each immunization given [1]
Inhalation Therapy	Each half hour of service
Laboratory:	
Clinical Microbiology	(a) Number of cultures (b) Number of smears
Hematology	(a) Number of blood counts [2] (b) Number of tests [2]
Laboratory—Continued	
Clinical Chemistry	(a) Number of examinations [3] (b) Number of tests [3]
Histology	(a) Number of specimens (b) Number of microscopic examinations
Cytology	Number of smears
Serology	Number of tests
Occupational Therapy	Each hour of instruction
Pharmacy	(a) Each prescription filled for outpatients (b) Each requisition filled for Outpatient Department
Physical Therapy	Each treatment rendered
Radiology:	
Diagnostic	(a) Each exposure taken (b) Each fluoroscopic examination (c) Each radioactive element test
Therapeutic	(a) Each X-ray treatment (b) Each treatment by radioactive elements
Tissue Bank	Each item furnished

[1] Each procedure in establishing an immunization should be counted as a unit of service.

[2] Each procedure, such as hematocrit, hemoglobin, sedimentation rate, or prothrombin determinations, should be recorded as a "test."

A "count" includes RBC, WBC, and differential, as well as platelet, reticulocyte, and other special types of blood counts, each to be recorded as a separate count.

[3] An "examination" which includes procedures such as examination of urine for color, pH, specific gravity, and microscopic, should be recorded as a single Unit of Service.

A "test" includes individual chemical determinations, such as testing urine for sugar, albumin, acetone, and diacetic acid, which should be recorded as separate Units of Service. Blood and spinal fluid tests should also be recorded as separate units.

PART II

Planning, Policies, Programs

Effective planning and evaluation of hospital outpatient services cannot be done without considering total community and hospital needs and resources. By the same token, the hospital itself must consider the community's needs for outpatient services in planning its total program.

Planning Factors

An essential step in planning outpatient services involves the review and analysis of factors in the community relating to total needs. Some of these factors include:

1. Population and community characteristics.
2. Vital statistics and health needs.
3. Resources (programs and services).
4. Utilization (patterns of use and quantity of services).
5. Patterns of medical practice.
6. Data on quality of services.
7. Trends.

Wherever applicable, the study and evaluation should review policies and programs, along with social, psychological, economic and related factors. Examples of some questions to be considered include:

1. What is the hospital's role, relationships, and responsibility to the following members of the community:
    a. The patient?
    b. Professional groups and individuals?
    c. Public at large?
    d. Police officials?
    e. Press?
    f. Other hospitals?
    g. Other community resources?
    h. Planning agencies and organizations?
    i. Organizations which establish standards?
    j. Educational programs of the hospital, medical groups, and governmental and voluntary health groups?
2. What factors influence utilization of outpatient services?
    a. Economics and culture of the community served?
    b. Availability of other resources?
    c. Geographical location?
    d. Ownership or sponsorship?
    e. Costs of services rendered?
    f. Benefit provisions of insurance coverage?
3. What determines the extent of services offered?
    a. Community demands and needs?
    b. Competency of staff?
    c. Interests of staff?
    d. Pressures and influences?
    e. Pattern of medical practice in the community?
    f. Availability of facilities?
    g. Teaching responsibilities?
4. What is the responsibility of the governing body for policies in relation to services?
5. How will operational policies and procedures be established?
    a. By order of the Hospital Administrator?
    b. By the Medical Chief of Staff (Clinical Director)?
    c. Joint action of a committee composed of representatives of Administration, Nursing Service, and Medical Staff?
    d. Other?
6. Who will be responsible for
    a. Administrative control and direction?
    b. Supervision of medical care?

7. How will clinical evaluation be made of services rendered?
    a. Establishment and action of a committee?
    b. Qualitative audits of medical activities, including records?
    c. Continuous review of activities by the Clinical Director?
    d. All of the above?
    e. Other?
8. What will be the staffing and personnel patterns?
    a. Composition of staff.
        (1) Categories of personnel
    b. Numbers required for coverage.
9. What legal aspects must be considered?
    a. Reports required by law:
        (1) Police department
        (2) Coroner's office
        (3) Health departments
        (4) Other
    b. System for authorization for surgical and other therapeutic procedures.
    c. Malpractice and liability insurance coverage.
    d. Licensure of staff members and other personnel.
10. What is the pattern of medical practice in the community as related to *emergency services*?
    a. Immediate diagnosis and care for emergencies only?
    b. Emergency care unit used as an extension of the private physician's office as a convenience to doctors?
    c. Use of emergency unit as a convenience and cost savings?
    d. As a referral point to other services, governmental and voluntary health agencies, or private medical practitioners?
    e. Use of the emergency unit by chronic disease patients?
    f. Use of the emergency unit for welfare beneficiaries?
11. How will patient charges be determined?
    a. Arbitrary determination?
    b. Ability to pay on part of patient?
    c. Actual cost basis?
    d. Comparison with other hospitals in area?
12. How will operating costs for services be met?
    a. Actual costs charged to patient?
    b. Subsidy by hospital inpatient charges?
    c. Subsidy by community contributions?
    d. Absorbed in hospital's operating expenses?
    e. Other?
13. Who will be responsible for
    a. Management and filing medical records?
    b. Obtaining signed authorizations for surgery, special treatments, and other procedures?
    c. Submitting police and coroner's case reports?
    d. Rendering statistical reports to the Hospital Administrator?
14. Are medical records to be
    a. Filed separately?
    b. Combined with inpatient records, if patient is admitted to hospital?
15. Who will be responsible for making
    a. Quantitative reviews and analysis of records?
    b. Evaluation of medical care rendered to patients?
    c. Recommendations for changes in administrative procedures?
    d. Periodic reviews of staff and other personnel needs, policy needs, and supply of equipment needs?
    e. Evaluation of administrative efficiency?
16. What physical facilities are needed?
    a. Entrance separate from the hospital main entrance?
    b. Special parking lot?
    c. Separate registration and admitting desk?
    d. Waiting rooms for patients, friends and families of patients, police officials, and ambulance drivers?
    e. Observation rooms?
    f. An isolation room for use by mental, alcoholic, or communicable disease patients?
    g. Plaster-cast room?
    h. A minor surgery and scrub room?
    i. Public telephones?
    j. Public toilets?
    k. Other?

17. Will the Outpatient Department utilize existing hospital adjunct services or provide separate
    a. Space and equipment for laboratory procedures?
    b. X-ray equipment?
    c. Anesthesia equipment?
    d. Pharmacy services; stocks of drugs and narcotics?
    e. Stocks of equipment and supplies?
    f. Physical medicine?
    g. Other?
18. What Clinical Units and Adjunct Services will be required? (See listing under definitions, pp. 3–4.)

Data Collection

From the preceding general base, specific methods of data collection relating to outpatient services will logically evolve. Complete, necessary data, in detail, are not listed here. Each situation will require knowledge of factors, such as staffing and space, as necessary, on a local basis. At least a minimum amount of data will be needed for identifying the existing hospital or hospitals, as suggested in the following guide:

IDENTIFICATION OF FACILITY

1. Name of Hospital _____
2. Address _____
3. Control or Ownership: Voluntary ____ Federal ____ State or Local Government ____ Proprietary____
4. Type of Service: General Short-Term ____ General Long-Term ____ Tuberculosis ____ Psychiatric____ Other (specify) _____
5. Name of Hospital's Chief Administrative Officer

Inpatient Data.—Beyond identification of the institution, certain information is needed for comparative purposes. Such data for inpatients need not be in detail, but a minimum is illustrated in the following form:

INPATIENT DATA

1. Total Bed Capacity _____
2. Annual Admissions _____
3. Average Daily Census _____
4. Average Length of Stay _____
5. Total Average Number of Full-Time (or equivalent) Hospital Employees (Excluding Employees in Outpatient Services) _____
6. Average Cost per Inpatient Day $ _____
7. Charges per Patient Day for
   (a) Single Bed Room $_____
   (b) Multiple Bed Room $_____
   (c) Open Ward Bed $_____

Outpatient Data.—For specific data from individual hospital services, the form presented below is suggested as a guide. Since it is suggested that outpatients be classified as *Emergency, Referred,* or *General,* a separate form should be completed for each category. Suggested terminology is given in Part I of this report.

The method of data collection from records of individual outpatients will vary. Alternative methods to be considered include

1. The compilation of data pertaining to all individuals recorded for the study period as having received outpatient services.

2. The compilation of data pertaining to all such individuals recorded in every other month of the study period.

3. The compilation of data pertaining to each tenth individual, or other statistically significant number, recorded for the study period.

OUTPATIENT DATA

NOTE: Data should be compiled separately for each of three types of outpatients (Emergency, Referred, or General). *Strike out the two categories which are not appropriate for listing on this page.*

(A) EMERGENCY (B) REFERRED (C) GENERAL

1. Total number of different individuals rendered care _____
2. Total number of Outpatient Visits _____
   (a) Number of New Visits _____
   (b) Number of Repeat Visits _____
3. Total number of Units of Service rendered _____

4. Predominant age group(s) served:
   (a) Under 6 years _____
   (b) 6 to 21 years _____
   (c) 22 to 40 years _____
   (d) 41 to 65 years _____
   (e) Over 65 years _____

5. Periods of highest peak workloads:
   (a) Months _____
   (b) Days _____
   (c) Hours:
   Midnight to 3:00 a.m. _____
   3:00 a.m. to 6:00 a.m. _____
   6:00 a.m. to 9:00 a.m. _____
   9:00 a.m. to noon _____
   Noon to 3:00 p.m. _____
   3:00 p.m. to 6:00 p.m. _____
   6:00 p.m. to 9:00 p.m. _____
   9:00 p.m. to midnight _____

6. Most common diagnosis, in numbers and order of frequency:

	Diagnosis	*Number of Cases*
(a)		
(b)		
(c)		
(d)		
(e)		

7. Average charge for each:
   (a) New Outpatient Visit $_____
   (b) Repeat Outpatient Visit $_____

8. Sources of payment to hospital, by percentages:

	Percent
(a) Directly by patient	
(b) Public Assistance Agencies	
(c) Other third-party payers	
(d) None	
(e) Other (specify)	

9. Methods of providing coverage by physicians:
   (a) Members of hospital medical staff, by rotation roster (full-time) _____
   (b) Members of hospital medical staff, by rotation roster (on call) _____
   (c) Salaried house physician (full-time) _____
   (d) Salaried house physician (on call) _____
   (e) Interns or residents (full-time) _____
   (f) Interns or residents (on call) _____
   (g) Other (specify) _____

10. Final disposition of outpatients (enter total numbers for appropriate categoryonly)

	OUTPATIENTS		
	Emergency	Referred	General
(a) Discharge to home			
(b) Transferred to inpatient status			
(c) Referred to care of private physician			
(d) Referred to other facilities			
(e) Died			
(f) Other			

Summary Sheet.—Information concerning the three categories of outpatients along with related data can then be combined on the following suggested Summary Sheet for analysis.

OUTPATIENT DATA SUMMARY SHEET

1. Average number of full-time (or equivalent employees assigned to the
   (a) Emergency services _____
   (b) Other outpatient services _____

2. Total average number of full-time (or equivalent) employees assigned to outpatient services _____

3. Number of different individuals:

	OUTPATIENTS			
	Total	Emergency	Referred	General
(a) Given outpatient care				
(b) Making new visits				
(c) Making repeat visits				

4. Number of Units of Service rendered

OUTPATIENTS			
Total	Emergency	Referred	General

5. Predominant age group(s) served:

	OUTPATIENTS			
	Total	Emergency	Referred	General
(a) Under 6 years				
(b) 6 to 21 years				
(c) 22 to 40 years				
(d) 41 to 65 years				
(e) Over 65 years				

6. Periods of highest peak workloads:

	OUTPATIENTS		
	Emergency	Referred	General
Months			
Days			
Hours: Midnight to 3:00 a.m.			
3:00 a.m. to 6:00 a.m.			
6:00 a.m. to 9:00 a.m.			
9:00 a. m. to noon			
Noon to 3:00 p.m.			
3:00 p.m. to 6:00 p.m.			
6:00 to 9:00 p. m.			
9:00 p.m. to midnight			

7. Average charge for each:

	OUTPATIENTS		
	Emergency	Referred	General
(a) New Visit			
(b) Repeat Visit			

8. Sources of payment to hospital, by percentages:

	OUTPATIENTS		
	Emergency	Referred	General
(a) Directly by patient			
(b) Public assistance agencies			
(c) Other third-party payers			
(d) None			
(e) Other (specify)			

9. Final dispositions (enter total numbers):

	OUTPATIENTS		
	Emergency	Referred	General
(a) Discharge to home			
(b) Transferred to inpatient status			
(c) Referred to care of private physician			
(d) Referred to other facilities			
(e) Died			
(f) Other (specify)			

10. Space allocated for outpatient facilities _____ square feet.

11. Space needed for adequate care _____ square feet.

Current and Projected Data

In measuring and projecting future hospital needs for an increasing population, planners for medical care facilities must consider known population growth. Table 1 presents data relating to facts and trends of the civilian resident population in the United States.

Current Data

Basic statistics concerning *all* hospitals, beds, and inpatient admissions, as summarized in table 2, serve as national indicators and points of departure in developing data relating to outpatient services.

Summary data relating to total outpatient visits are presented in tables 3–5, and chart 1. These data show hospitals reporting outpatient visits without indicating the type of visit and those separating the data into Emergency, Referred, and General Outpatient Visits. They also reveal comparable data for hospitals by type of ownership.

TABLE 1. U.S. Civilian Resident Population 1958–1970

Year	Population (in millions)
1958	171.2
1960	177.9
1962	184.6
1968	204.7
1970	211.5

Source: U.S. Census Bureau Population Reports, Series P–25, No. 251, projected by 3.35 million annually.

TABLE 2. Hospitals and Outpatient Visits, 1962

Item	All Registered Hospitals		Hospitals Reporting Outpatient Visits	
	Total	Percent	Total	Percent
All Hospitals	7,028	100	5,291	75.3
All Beds	1,689,414	100	1,126,088	66.7
Inpatient Admissions	26,531,000	100	[1] 17,000,000	64
Average Inpatient Census	1,406,818	100	920,462	65.4
Average Occupancy	—	83.3	—	81.7

TOTAL OUTPATIENT VISITS REPORTED: 99,382,469

[1] Estimated.

Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1968.

TABLE 3. Outpatient Visits in All Registered Hospitals, 1962

Item	Type of Hospital		
	Federal	Non-Federal	Total
Total Registered Hospitals	447	6,581	7,028
Total Beds	177,677	1,511,737	1,689,414
Inpatient Census	154,400	1,252,418	1,406,818
Hospitals Reporting Outpatient Visits	370	4,921	5,291
Total Beds	133,218	992,865	1,126,083
Inpatient Census	114,318	806,144	920,462
Total Outpatient Visits	25,968,345	73,414,125	99,382,470
Hospitals Reporting Outpatients by Type of Visit	87	4,210	4,297
Total Beds	41,046	897,247	938,293
Inpatient Census	35,559	731,038	766,597
Total Outpatient Visits	3,337,704	67,130,551	70,468,255
Emergency Outpatient Visits	335,883	19,867,820	20,203,703
Referred Outpatient Visits	37,255	16,507,004	16,544,259
General Outpatient Visits	2,964,566	30,755,727	33,720,293
Hospitals Reporting Outpatients but Not by Type of Visit	283	711	994
Total Beds	92,172	95,618	187,790
Inpatient Census	78,759	75,106	153,865
Total Outpatient Visits	22,630,641	6,283,574	28,914,215

Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1963.

TABLE 4. Total Hospitals, Beds, Inpatient Census, Total Hospitals Reporting Outpatient Visits, and Total Outpatient Visits Reported, by Ownership, 1962

Item	Type of Hospital				
	Voluntary	Federal	State and Local Government	Proprietary	Totals
Total Hospitals	3,623	447	1,968	990	7,028
Total Beds	507,108	177,677	954,690	49,939	1,689,414
Inpatient Census	391,955	154,400	826,207	34,256	1,406,818
Hospitals Reporting Outpatient Visits	3,012	370	1,388	521	5,291
Total Outpatient Visits Reported	46,677,481	25,968,345	28,588,631	3,148,012	99,382,469

Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1963.

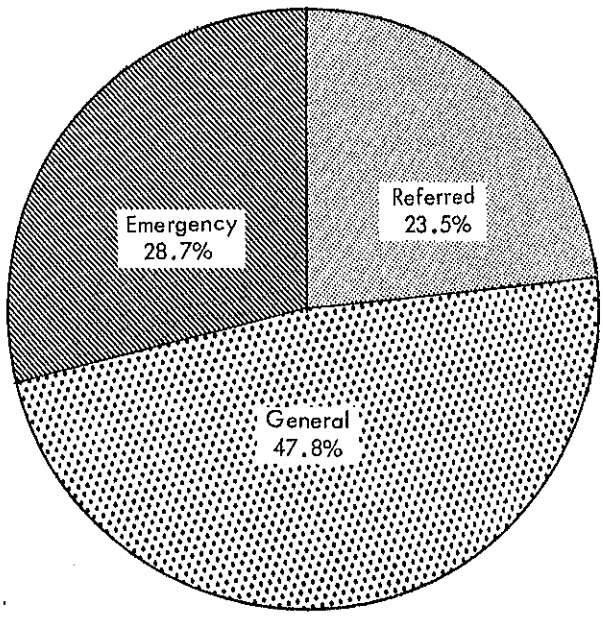
TABLE 5. Hospitals Reporting Outpatient Visits, 1962

Item	Hospitals Reporting Outpatient Visits by Type of Visit	Hospitals Reporting Outpatient Visits but not by Type of Visit	Totals
Number of Hospitals	4,297	994	5,291
Total Beds	988,293	187,790	1,126,083
Inpatient Census	766,597	153,865	920,462
Total Outpatient Visits Reported	70,468,253	28,914,215	99,382,469
Emergency Outpatient Visits	20,203,703 (28.7%)	[1] 8,298,380	[2] 28,502,083
Referred Outpatient Visits	16,544,258 (23.5%)	[1] 6,794,840	[2] 23,339,098
General Outpatient Visits	33,720,293 (47.8%)	[1] 13,820,995	[2] 47,541,288

[1] Estimates of these visits based on same percentages as in hospitals actually reporting by type of visit.
[2] Reported and estimated.

Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1963.

CHART 1. *Percentages of Outpatient Visits to All Hospitals, by Type of Visit, 1962*



Based on 99,382,469 Reported Outpatient Visits
Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1963

Data compiled from all hospitals reporting Outpatient Visits disclosed the averages shown in table 6.

TABLE 6. All Hospitals Reporting Outpatient Visits, a Profile, 1962

Average Number of Beds	213
Average Inpatient Census	174
Percent Occupied Beds	81.7
Annual Average Number of Outpatient Visits per Hospital	18,783
Annual Average Number of Outpatient Visits per Bed	88
Annual Average Number of Outpatient Visits per Occupied Bed	108
Average Daily Number of Outpatient Visits (365 Days per Year)	51
Ratio of Daily Outpatient Visits to Each Occupied Bed	1:3.41

Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1963.

Estimates and Projections

For a number of years, through 1958, the American Hospital Association listed outpatient visits as reported by hospitals in the United States. While such visits were not reported for the years 1959 through 1961, they have been reported and listed for 1962.

In order to estimate the impact of outpatient visits on hospitals for the years 1963 through 1970, the 1958 and 1962 figures were used as a base in charts 2–4 and tables 7–23. Figures for 1960 were established as an arithmetical midpoint between figures reported for

1958 and 1962. Projections for Emergency Outpatient Visits were made at the rate of 2.6 million annually. Other Outpatient Visits were projected at the rate of 1.1 million per year.

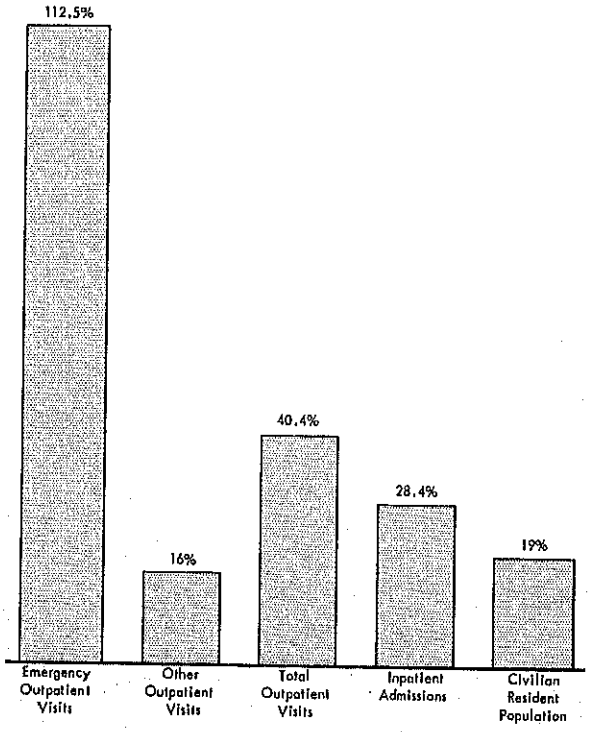
Variable factors which should be considered in reviewing these figures include:

1. The margin for error inherent in arbitrary straight-line projection of figures for estimates;
2. Not all hospitals registered by the A.H.A. reported outpatient visits; and
3. The difference in terminology used by hospitals in their reports to the A.H.A. with reference to categorized outpatient visits.

Projections for inpatient admissions, as shown in chart 2, are based on actual admissions reported to the A.H.A. for the years 1958 through 1962, with average annual increments of 0.7 million.

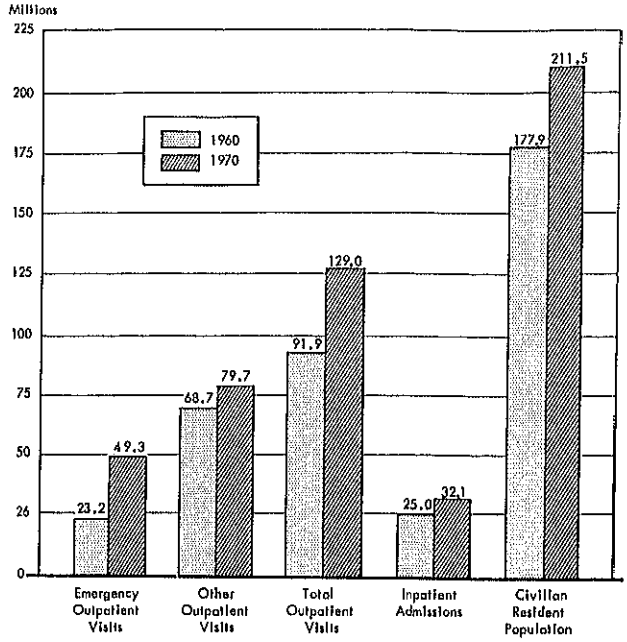
Population increases were projected at the rate of 3.35 million per year, based on figures reported for 1960, and estimated for years 1956 and 1970 by the U.S. Bureau of Census.

CHART 2. *Percentage Increases in Outpatient Visits and Inpatient Admissions to All Hospitals, and Population Increase, Projected From 1960 to 1970*



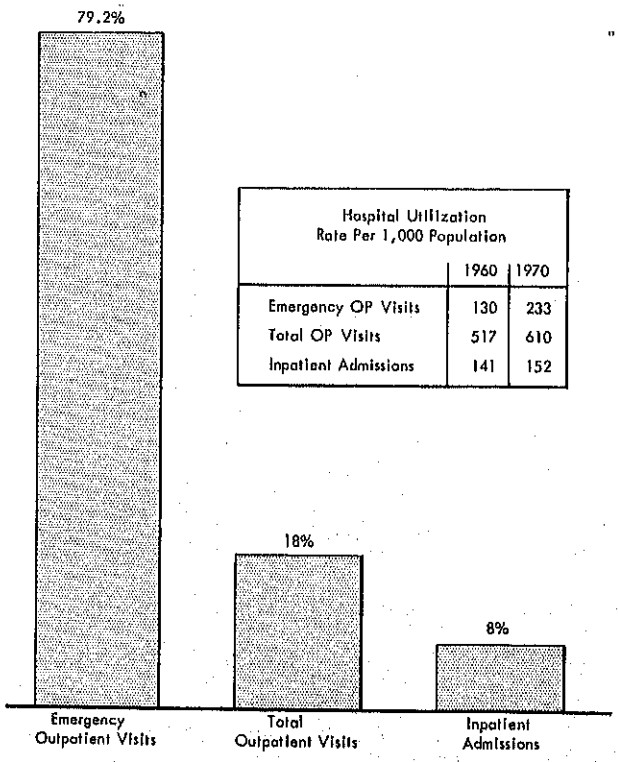
Sources: *Hospitals, Guide Issue*, J.A.H.A., 1959 and 1963, projected by 2.6 million annually for Emergency Visits, 1.1 million for Other Outpatient Visits, and 0.7 million for Inpatient Admissions. Population figures from U.S. Census Bureau Population Reports, Series P-25, projected by 3.35 million annually.

CHART 3. *Number of Outpatient Visits and Inpatient Admissions to All Hospitals, and Population Increase, Projected From 1960 to 1970*



See "Sources" for chart 2.

CHART 4. *Increase in Patient Loads for All Hospitals, Per 1,000 Population, Projected From 1960 to 1970*



Hospital Utilization
Rate Per 1,000 Population

	1960	1970
Emergency OP Visits	130	233
Total OP Visits	517	610
Inpatient Admissions	141	152

Sources: *Hospitals, Guide Issue*, J.A.H.A., 1959 and 1963, for projections of Outpatient Visits and Inpatient Admissions. Population figures were projected from U.S. Census Bureau Population Reports, Series P-25.

TABLE 7. Estimated Outpatient Visits to All Hospitals, 1958–1970

Year	Total Visits (in millions)	Emergency Visits (in millions)	Other Outpatient Visits (in millions)
1958.....	[1] 84.5	[1] 18.0	[1] 66.5
1960.....	[2] 91.9	[2] 23.2	[2] 68.7
1962.....	[1] 99.4	[2] 28.5	[2] 70.9
1968.....	[2] 121.6	[3] 44.1	[4] 77.5
1970.....	[2] 129.0	[3] 49.3	[4] 79.7

[1] Reported by American Hospital Association.
[2] Estimated figures.
[3] Projected by annual average increase of 2.6 million.
[4] Projected by annual average increase of 1.1 million.

Notes:
Percentage increases in Emergency Visits:
1958–1968=145 percent.
1960–1970=112.5 percent.
Percentage increases in Other Outpatient Visits:
1958–1968=16.5 percent.
1960–1970=16 percent.
Percentage increases in Total Outpatient Visits:
1958–1968=48.9 percent.
1960–1970=40.4 percent.

TABLE 8. Outpatient Visits, All Non-Federal, Short-Term, General and Other Special Hospitals, 1962

Total Registered Hospitals	5,564
Total Beds	676,795
Inpatient Census	508,791
Hospitals Reporting Outpatient Visits	4,401
Total Beds	579,963
Inpatient Census	439,509
Total Outpatient Visits	70,727,474
Hospitals Reporting Outpatients by Type of Visit	3,768
Total Beds	529,379
Inpatient Census	403,727
Total Outpatient Visits	64,914,021
Emergency Outpatient Visits	19,796,224
Referred Outpatient Visits	16,206,555
General Outpatient Visits	28,911,242
Hospitals Reporting Outpatients But Not by Type of Visit	633
Total Beds	50,584
Inpatient Census	35,782
Total Outpatient Visits	5,813,453

Source: *Hospitals, Guide Issue,* J.A.H.A., August 1, 1963.

TABLE 9.—Non-Federal, Short-Term, General and Other Special Hospitals Reporting Outpatient Visits, 1962

Item	Total	Voluntary	State and Local Government	Proprietary
Average Number of Beds.....	132	148	123	55
Average Inpatient Census.....	100	114	89	38
Percent Occupied Beds.....	76	77	72	69
Annual Average Number Outpatient Visits per Hospital....	16,071	16,113	20,076	6,577
Annual Average Number Outpatient Visits per Bed.....	121	109	163	120
Annual Average Number Outpatient Visits per Occupied Bed.....	162	141	225	173
Average Daily Number Outpatient Visits per Hospital (365 days per year).....	44	44	55	18
Ratio Daily Outpatient Visits to Each Occupied Bed.....	1:2.27	1:2.59	1:1.62	1:2.11

Source: *Hospitals, Guide Issue,* J.A.H.A., August 1, 1963.

TABLE 10. Estimated Outpatient Visits to Non-Federal, Short-Term, General Hospitals, by Size, 1962

Number of Beds	Total Outpatient Visits	Emergency Outpatient Visits	Referred Outpatient Visits	General Outpatient Visits
50.....	4,250	1,400	1,100	1,750
100.....	8,750	3,800	2,700	2,750
200.....	21,300	7,600	6,700	7,000
300.....	36,650	11,900	11,500	13,250
400.....	61,100	16,400	18,200	26,500
500.....	85,300	21,200	20,100	44,000
600.....	106,600	25,900	18,700	62,000
700.....	127,300	30,600	17,200	79,500

Source: *Hospitals, Guide Issue,* J.A.H.A., August 1, 1963.

TABLE 11. Estimated Monthly and Daily Averages of Outpatient Visits for Non-Federal, Short-Term, General Hospitals [1]

Number of beds	Average Number Outpatient Visits Monthly				Average Number Outpatient Visits Daily			
	Total	Emergency	Referred	General	Total	Emergency [2]	Referred [3]	General [3]
50	353	117	91	145	15	4	4	7
100	733	276	229	229	29	9	10	10
200	1,774	633	558	583	73	21	25	27
300	3,054	992	958	1,104	128	33	44	51
400	5,091	1,367	1,516	2,208	217	45	70	102
500	7,109	1,767	1,675	3,667	304	58	77	169
600	8,883	2,158	1,558	5,167	381	71	72	238
700	10,608	2,550	1,433	6,625	456	84	66	306

[1] Based on figures in table 10.
[2] Based on 365 days per year.
[3] Based on 260 days per year (5-day work week).

Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1963.

TABLE 12. Estimated Outpatient Visits to Non-Federal, Short-Term, General Hospitals, 1958–1970

Year	Total Visits (in millions)	Emergency Visits (in millions)	Other Outpatient Visits (in millions)
1958	[1] 62.3	[1] 17.1	[1] 45.2
1960	[2] 66.5	[2] 19.3	[2] 47.2
1962	[1] 70.7	[2] 21.5	[2] 49.2
1968	[2] 83.3	[4] 28.1	[3] 55.2
1970	[2] 87.5	[4] 30.3	[3] 57.2

[1] Reported by American Hospital Association.
[2] Estimated figures.
[3] Projected by annual increase of 1.0 million.
[4] Projected by annual increase of 1.1. million.

Notes:

Percentage increases in Emergency Visits:
1958–1968=64.8 percent.
1960–1970=57.0 percent.

Percentage increases in Other Outpatient Visits:
1958–1968=22.1 percent.
1960–1970=21.2 percent.

Increases in Total Outpatient Visits:
1958–1968=33.7 percent.
1960–1970=31.6 percent.

TABLE 13. Estimated Inpatient Admissions to Non-Federal, Short-Term, General Hospitals, 1958–1970

Year	Inpatient Admissions (in millions) [1]	Ratio of Outpatient Visits to One Inpatient Admission
1958	21.7	2.87
1960	23.0	2.89
1962	24.3	2.91
1968	28.5	2.92
1970	29.9	2.93

[1] Figures for years 1963–1970 projected by 0.7 million annual increases.

Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1963.

TABLE 14. Estimated Increase in Patient Loads per 1,000 Population for Non-Federal, Short-Term, General Hospitals, 1958–1970

Item	Rate per 1,000 Population					Percentage of Increase	
	1958[1]	1960[1]	1962[1]	1968[2]	1970[2]	1958–1968	1960–1970
Emergency Outpatient Visits	99.9	108.5	116.5	137.3	143.3	37.4	32.1
Other Outpatient Visits	264.0	265.3	266.5	269.7	270.4	2.2	1.9
Total Outpatient Visits	363.9	373.8	383.0	406.9	413.7	11.8	10.7
Inpatient Admissions	126.8	129.3	131.6	139.2	141.4	9.8	9.4
Number of Outpatient Visits per Inpatient Admissions	2.87	2.89	2.91	2.92	2.93	—	—

[1] Source: *Hospitals, Guide Issues*, J.A.H.A., 1959–1963.
[2] Figures projected by 2.6 millions annually for Emergency Outpatient Visits, by 1.1 millions annually for Other Outpatient Visits, and by 0.7 million annually for Inpatient Admissions for years 1963–1970.

TABLE 15. Outpatient Visits to Voluntary Short-Term General Hospitals, 1962

Total Registered Hospitals	3,346
Total Beds	471,868
Inpatient Census	362,632
Hospitals Reporting Outpatient Visits	2,850
Total Beds	421,195
Inpatient Census	325,285
Total Outpatient Visits	45,920,748
Hospitals Reporting Outpatients by Type of Visit	2,495
Total Beds	386,798
Inpatient Census	300,473
Total Outpatient Visits	42,678,795
Emergency Outpatient Visits	13,097,741
Referred Outpatient Visits	14,421,257
General Outpatient Visits	15,159,797
Hospitals Reporting Outpatients but Not by Type of Visit	355
Total Beds	34,397
Inpatient Census	24,812
Total Outpatient Visits	3,241,953

Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1963.

TABLE 16. Outpatient Visits Reported in Voluntary, Short-Term, General Hospitals, by Size, 1962

Number of Beds	Number of Hospitals Reporting Outpatient Visits	Percent of VSTG Hospitals Reporting	Total Outpatient Visits Reported	Percent of Outpatient Visits Reported	Number of Beds	Percent of Beds
Total	2,850	100.0	45,920,748	100.0	421,195	100.0
Under 25	161	5.7	442,210	1.0	2,953	.7
25–49	528	18.5	1,969,573	4.3	18,804	4.5
50–99	708	24.8	8,476,500	7.6	49,863	11.7
100–199	670	23.5	8,575,404	18.7	93,688	22.3
200–299	405	14.2	10,383,294	22.6	96,604	22.9
300–399	213	7.5	8,598,642	18.7	71,239	16.9
400–499	90	3.2	5,378,109	11.7	39,084	9.3
500 and over	75	2.6	7,097,016	15.4	49,460	11.7

Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1963.

TABLE 17. Estimated Outpatient Visits to Voluntary, Short-Term, General Hospitals, 1958–1970

Year	Total Visits (in millions)	Emergency Visits (in millions)	Other Outpatient Visits (in millions)
1958.....	[1] 38.4	[1] 11.2	[1] 27.2
1960.....	[2] 42.2	[2] 12.6	[2] 29.6
1962.....	[1] 45.9	[2] 14.1	[2] 31.8
1968.....	[2] 57.3	[3] 18.3	[4] 39.0
1970.....	[2] 61.1	[3] 19.7	[4] 41.4

[1] Reported by American Hospital Association.
[2] Estimated figures.
[3] Projected by annual average increase of 0.7 million.
[4] Projected by annual average increase of 1.1 million.

Notes:

Percentage increases in Emergency Visits:
1958–1968=63.4 percent.
1960–1970=56.3 percent.

Percentage increases in Other Outpatient Visits:
1958–1968=43.4 percent.
1960–1970=39.9 percent.

Percentage increases in Total Outpatient Visits:
1958–1968=49.2 percent.
1960–1970=44.8 percent.

TABLE 18. Outpatient Visits, State and Local Government, Short-Term, General Hospitals, 1962

Total Registered Hospitals	1,358
Total Beds	164,518
Inpatient Census	118,960
Hospitals Reporting Outpatient Visits	1,082
Total Beds	133,087
Inpatient Census	96,439
Total Outpatient Visits	21,722,295
Hospitals Reporting Outpatients by Type of Visit	893
Total Beds	120,755
Inpatient Census	88,147
Total Outpatient Visits	19,995,465
Emergency Outpatient Visits	6,210,372
Referred Outpatient Visits	1,541,185
General Outpatient Visits	12,243,908
Hospitals Reporting Outpatients but Not by Type of Visit	189
Total Beds	12,332
Inpatient Census	8,292
Total Outpatient Visits	1,726,830

Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1963.

TABLE 19. Estimated Outpatient Visits to State and Local Government, Short-Term, General Hospitals, 1958–1970

Years	Total Visits (in millions)	Emergency Visits (in millions)	Other Outpatient Visits (in millions)
1958.....	[1] 20.8	[1] 5.4	[1] 15.4
1960.....	[2] 21.2	[2] 6.0	[2] 15.2
1962.....	[1] 21.7	[2] 6.7	[2] 15.0
1968.....	[2] 22.9	[3] 8.5	[4] 14.4
1970.....	[2] 23.3	[3] 9.1	[4] 14.2

[1] Reported by the American Hospital Association.
[2] Estimated figures.
[3] Projected by annual average increases of 0.3 million.
[4] No increases in this category were reported for 1958–1962. Increases reported were in the Emergency Visit category. Other Outpatient Visits *decreased* by 0.1 million annually.

Notes:

Percentage increases in Emergency Visits:
1958–1968=57.4 percent.
1960–1970=51.7 percent.

Percentage increases in Total Outpatient Visits:
1958–1968=10.1 percent.
1960–1970=9.9 percent.

TABLE 20. Outpatient Visits to Proprietary, Short-Term, General Hospitals, 1962

Total Registered Hospitals	860
Total Beds	40,409
Inpatient Census	27,199
Hospitals Reporting Outpatient Visits	469
Total Beds	25,681
Inpatient Census	17,785
Total Outpatient Visits	8,084,431
Hospitals Reporting Outpatients by Type of Visit	380
Total Beds	21,826
Inpatient Census	15,107
Total Outpatient Visits	2,239,761
Emergency Outpatient Visits	488,111
Referred Outpatient Visits	244,113
General Outpatient Visits	1,507,537
Hospitals Reporting Outpatients but Not by Type of Visit	89
Total Beds	3,855
Inpatient Census	2,678
Total Outpatient Visits	844,670

Source: *Hospitals, Guide Issue*, J.A.H.A., August 1, 1963.

TABLE 21. Outpatient Visits to All Tuberculosis Hospitals, 1962

Item	Total	Federal	Non-Federal
Total Registered Hospitals	214	11	203
Total Beds	47,819	3,132	44,687
Inpatient Census	35,454	2,631	32,823
Hospitals Reporting Outpatient Visits	126	4	122
Total Beds	26,493	1,140	25,353
Inpatient Census	19,175	927	18,248
Total Outpatient Visits	581,820	13,680	568,140
Hospitals Reporting Outpatients by Type of Visit	107	1	106
Total Beds	22,824	255	22,569
Inpatient Census	16,558	155	16,403
Total Outpatient Visits	529,149	11,460	517,689
Emergency Outpatient Visits	529	—	529
Referred Outpatient Visits	96,180	—	96,180
General Outpatient Visits	432,440	11,460	420,980
Hospitals Reporting Outpatients but Not by Type of Visit	19	3	16
Total Beds	3,669	885	2,784
Inpatient Census	2,617	772	1,845
Total Outpatient Visits	52,671	2,220	50,451

Source: *Hospitals, Guide Issue,* J.A.H.A., August 1, 1963.

TABLE 23. Estimated Outpatient Visits to Federal, General Hospitals, 1958–1970

Year	Total Visits (in millions)
1958.....	[1] 19.1
1960.....	[2] 22.4
1962.....	[2] 25.9
1968.....	[3] 36.1
1970.....	[3] 39.5

[1] Reported by American Hospital Association.
[2] Estimated figures.
[3] Projected by annual average increases of 1.7 millions.

Percentage increases in Total Outpatient Visits:
1958–1968=90.0 percent.
1960–1970=76.8 percent

NOTE: The relative minor number of Emergency Outpatient Visits reported by American Hospital Association for the years 1958 and 1962 does not permit valid projections.

TABLE 22. Outpatient Visits to All Psychiatric Hospitals, 1962

Item	Total	Federal	Non-Federal
Total Registered Hospitals	535	44	491
Total Beds	784,240	67,459	716,781
Inpatient Census	712,174	63,589	648,585
Hospitals Reporting Outpatient Visits	261	30	231
Total Beds	392,658	41,421	351,237
Inpatient Census	356,652	38,860	317,792
Total Outpatient Visits	955,837	64,255	891,582
Hospitals Reporting Outpatients by Type of Visit	196	9	187
Total Beds	324,040	12,400	311,640
Inpatient Census	293,732	11,637	282,095
Total Outpatient Visits	720,195	17,859	702,336
Emergency Outpatient Visits	18,751	191	18,560
Referred Outpatient Visits	57,827	78	57,749
General Outpatient Visits	643,617	17,590	626,027
Hospitals Reporting Outpatients but Not by Type of Visit	65	21	44
Total Beds	68,618	29,021	39,597
Inpatient Census	62,920	27,223	35,697
Total Outpatient Visits	235,642	46,396	189,246

Source: *Hospitals, Guide Issue,* J.A.H.A., August 1, 1963.

Emergency Outpatient Services

The relationship of the Emergency Service Unit to outpatients is similar to that of the Intensive Care Unit to inpatients. The Emergency Service Unit should be a vital part of the Outpatient Department, both organizationally and administratively. In 1961, 93.1 percent of the 5,309 short-term, general, and other special hospitals in the country reported maintaining an Emergency unit, more than the number reporting obstetrical delivery rooms.

From 1954 to 1958 Outpatient visits increased 30 percent to 62 million, 34 million of which were general visits, 11 million unspecified, and *17 million Emergency Visits—an increase in the latter of 81 percent.*

A nationwide survey of hospital Emergency Services by Dr. James R. McCarroll and Dr. Paul A. Skudder of the Cornell Trauma Research Group of the Cornell University Medical College, cosponsored by the American College of Surgeons and the American Hospital Association, indicated a change in function for Emergency services, rather than a simple increase in number of visits for treatment of accidental injuries.[2] Stratified and random sampling of 330 hospitals in 4 major geographic regions, including metropolitan and rural areas, disclosed some significant information:

(1) The type of cases seeking Emergency care, by percentages, were:

	Percent
General surgery	27
Medicine	27
Pediatrics	14
Orthopedics	14
Other	18

(2) Of all patients visiting the Emergency unit, 58 percent were considered to have clinical emergency problems.

(3) Eighteen percent of all Emergency patients were subsequently admitted to the hospital as Inpatients.

(4) Accidents accounted for one-third of all Emergency visits.

(5) Utilization of Emergency unit services, by time shifts, in percentages, were:

	Percent
Day shift	47
Evening shift	40
Night shift	13

(6) *A 22-percent increase in visits on Saturday and Sunday* was due almost entirely to visits by children and adolescents. Visits by adults showed no significant increase on weekends.

(7) The increase in Emergency visits has ranged from more than 400 percent to 600 percent in other hospitals.

The report notes that the increased use of Emergency facilities indicates a basic shift in patterns of medical care with demands on such facilities now representing all aspects of medical practice.

A survey of a large teaching hospital in a metropolitan area revealed that 50 percent of the patients entering the Emergency Services Unit were classified clinically as urgent, 31 percent were nonurgent, 15 percent were scheduled visits, and 4 percent uncertain.

The Committee on Trauma of the American College of Surgeons has recently published a booklet entitled "A Model of a Hospital Emergency Department." This booklet states that the Emergency Unit must become the combined responsibility of all branches of the hospital staff, adding that—

The public has come to look upon the emergency department as the community medical center where any may apply, with any complaint, at any hour of the day or night, and expect prompt and courteous attention as his due. This concept must be accepted as a community obligation by governing boards, hospital administrators, and the profession.

All of the foregoing would indicate not only an actual increase in real emergencies, but that the public more and more looks to the emergency care unit for "instant medical care." Table 24 shows trends in Emergency Outpatient Services.

TABLE 24. Trends in Emergency Outpatient Visits, 1958–1970

A. ALL REPORTING HOSPITALS

	1958 [1]	1960 [2]	1962	1968 [2]	1970 [2]
Total Outpatient Visits (in millions)	84.5	91.9	[1]99.4	121.6	129.0
Total Emergency Visits (in millions)	18.0	23.2	[2]28.5	44.1	49.3
Percent of Emergency Visits to Total Outpatient Visits	21.3	25.2	[2]28.7	36.3	38.2

[1] Reported by American Hospital Association.
[2] Estimated.

B. NON-FEDERAL, SHORT-TERM, GENERAL HOSPITALS

	1958 [1]	1960 [2]	1962	1968 [2]	1970 [2]
Total Outpatient Visits (in millions)	62.3	66.5	[1]70.7	83.3	87.5
Total Emergency Visits (in millions)	17.1	19.3	[2]21.5	28.1	30.3
Percent of Emergency Visits to Total Outpatient Visits	27.4	29.0	[2]30.4	33.7	34.6

[1] Reported by American Hospital Association.
[2] Estimated.

(*Continued*)

[2] McCarroll, James R, and Skudder, Paul A., "Conflicting Concepts of Function Shown in National Survey." *Hospitals*, Journal of the American Hospital Association. 34: 35–38, December 1, 1960.

C. VOLUNTARY, SHORT-TERM, GENERAL HOSPITALS

	1958[1]	1960[2]	1962	1968[2]	1970[2]
Total Outpatient Visits (in millions)	38:4	42.2	[1]45.9	57.3	61.1
Total Emergency Visits (in millions)	11.2	12.6	[2]14.1	18.3	19.7
Percent of Emergency Visits to Total Outpatient Visits	29.2	29.9	[2]30.7	31.9	32.2

[1] Reported by American Hospital Association.
[2] Estimated.

D. STATE and LOCAL GOVERNMENT SHORT-TERM, GENERAL HOSPITALS

	1958[1]	1960[2]	1962	1968[2]	1970[2]
Total Outpatient Visits (in millions)	20.8	21.2	[1]21.7	22.9	23.3
Total Emergency Visits (in millions)	5.4	6.0	[2]6.7	8.5	9.1
Percent of Emergency Visits to Total Visits	26.0	28.3	[2]30.9	37.1	39.1

[1] Reported by American Hospital Association.
[2] Estimated.

Outpatient Services in Teaching Hospitals

With the growing importance of Outpatient Services in comprehensive medical programs, such services in university teaching hospitals are receiving increasing emphasis as a vital element in medical teaching. These services are a valuable teaching resource for developing full patient care competence in the medical student, the intern, and the resident physician. They also have special value in training and orienting student and graduate nurses, social workers, and other paramedical persons.

The Outpatient Department provides the student with an opportunity to observe and treat patients under conditions similar to those in a private office. Under the direction of a preceptor with whom all diagnoses and treatments are discussed, he sees patients with a wide variety of diseases, thereby gaining invaluable knowledge and experience. Because outpatient areas often provide special facilities such as gynecology, ophthalmology, otolaryngology, and urology that are not usually duplicated within the inpatient sections of the hospital, an increasing number of the ambulatory, wheelchair, or bed-fast inpatients are seen in the Outpatient Department for either diagnostic or therapeutic services.

Some university teaching hospitals find that more than half of their current emergency caseload consists of medical, pediatric, and obstetrical problems, and less than 40 percent are traumatic surgical cases. This is due to a growing trend on the part of the public to regard the emergency service of the university teaching hospital as a community medical center where anyone, young or old, may apply with any complaint, at any hour of the day or night, and expect to receive prompt, adequate service. Whereas the emergency service traditionally was the responsibility of the department of surgery, it has now become the responsibility of all the clinical departments in the hospital.

Since the status of outpatient care is becoming increasingly dynamic, it seems inconceivable that teaching hospitals will not have increased outpatient loads in the future.

The Directory of Approved Internships and Residencies for 1962, published by the American Medical Association, listed 1,475 institutions, of which 1,361 reported having a total of 802,740 beds. In 803 institutions, 12,637 intern positions were offered, and 1,285 offered 36,412 resident positions. Other data relating to outpatient services in connection with intern and residency programs presented in the Directory are incorporated in tables 25–29.

TABLE 25. Outpatient Visits to Hospitals With Interns and Residents, 1961

	Number of Hospitals Reporting	Number of Visits Reported	Percent of total
Emergency Visits	754	13,413,812	28.0
Referred Visits	441	8,407,264	17.5
General Visits	718	26,237,136	54.5
Total	.....	48,058,212	100.0

TABLE 26. Outpatient Visits to Specialty Clinics in Hospitals With Residencies, 1961

Clinic	Number of Institutions Reporting Residency	Number of Outpatient Visits
Internal Medicine	562	7,901,745
General Practice	152	1,322,470
Physical Medicine and Rehabilitation	80	647,610
General Surgical	694	5,903,036
Orthopedic Surgery	302	1,563,995
Neurological Surgery	115	184,022
Plastic Surgery	61	133,522
Thoracic Surgery	91	92,784
Urological	230	667,492
Obstetrics-Gynecology	426	3,750,994
Ophthalmology	175	1,836,507
Otolaryngology	122	891,985
Pediatric Allergy	19	59,481
Pedriatric	288	3,618,673
Child Psychiatry	67	352,845
Psychiatry	230	1,345,660
Neurology	96	207,191
Colon and Rectal Surgery	12	48,101
Dermatology	74	618,648
Total Outpatient Visits		31,096,261

TABLE 27. Workload of 723 Hospitals Reporting *Pathology* Residency, 1961

Procedures	Number Reported
Autopsies	204,864
Laboratory Examinations	195,083,766
Surgical Specimens Examined	4,504,343
Microscopic Examinations	3,886,879
Total	203,679,852

TABLE 28. Workload of 320 Hospitals Reporting *Radiology* Residency, 1961

Procedures	Number Reported
X-ray Examinations	13,791,446
Radium Treatments	23,343
Deep Therapy Treatments	1,729,126
Superficial Therapy Treatments	112,297
Total	15,656,212

TABLE 29. Outpatient Visits in Hospitals With Interns and/or Residency Programs, 1961

Number of Beds	General Visits	Referred Visits	Emergency Visits	Total Outpatient Visits	Percentage of Emergency Visits to Total Visits
50	—	—	—	—	—
100	—	—	—	—	—
200	13,500	11,500	10,000	35,000	28.6
300	17,500	15,000	13,000	45,500	28.6
400	28,000	18,000	16,000	62,000	25.8
500	43,000	22,500	20,000	85,500	23.4
600	60,000	37,000	24,000	121,000	19.8
700	73,000	48,000	28,500	149,500	19.1

Source: Directory of Approved Internships and Residencies. Education Number, *The Journal of the American Medical Association*, November 17, 1962.

Financing Outpatient Services

Programs, services, costs, charges, and methods of accounting for outpatient care vary so widely as to preclude documenting completely valid figures without considerable exploration, study, and analysis.

Many hospitals simply diffuse outpatient service expenses by incorporating them into total operating costs which are then allocated to inpatient costs. Thus, no breakdown of inpatient and outpatient expenses is given.

Costs of outpatient care, and particularly emergency services, carry an element of cost not directly related to numbers of patients nor to units of service. This is the "standby" or readiness to serve, which, in a way, is somewhat analogous to the inpatient maternity service.

Charges range from nominal fees for indigent or medically indigent patients, to charges per unit of service, to an inclusive flat rate. Often these figures are established somewhat arbitrarily and without particular regard to actual expense to the hospital. Ordinarily the hospital charges only for use of its facilities.

In a report of departmental expense per patient day in 809 general hospitals classified by bed capacity, inpatient expense per patient day, and average length of stay, for the year 1952,

the average cost per outpatient visit in each hospital was $3.39. Outpatient expenses represented 5.7 percent of the total expenses in the hospital.[3]

In 1958, the American Hospital Association reported that 2,213 non-Federal, short-term, general hospitals used a flat rate for Emergency room charges, with an average charge of $3.47.[4]

Recent estimates of costs for Outpatient Services range from $5 to $15 per visit, with an average approaching $10. Based on these figures, it can be estimated that in 1962, hospitals expended approximately $1 billion in providing outpatient services. This is about 10 percent of total expenditures for hospital care. With this volume of spending, detailed studies in cost accounting for such services seem indicated.

Physical Facilities for Outpatient Services

Outpatient visits to all hospitals have increased by more than two-thirds in the past 10 years. This increase, coupled with new patterns of medical care in the community, has demanded serious attention to requirements for physical facilities for outpatient services. Architects' present-day plans for such services reflect an awareness of these influencing factors. New concepts of outpatient services are being explored to determine medical and administrative needs for physical facilities. In addition, requirements for renovation or replacement of present outpatient physical facilities are being reviewed.

Location

Conceiving the Outpatient Department to be an integral and major department of the hospital, planners are locating such facilities in close proximity to other services. They are being located either within the main area of the hospital or in a separate wing or building attached to the hospital. In either event, the Outpatient facility is so located as to be readily accessible to the public, hospital patients, and employees.

The Emergency Service Unit, a major responsibility of and within the organizational pattern of the outpatient services, has been found to be best located as a part of the total Outpatient area, but with a separate entrance.

Space

At present, there are no universally reliable figures on needed space requirements for outpatient services. It is not known whether a definite relationship can be established between the number of square feet and the number of outpatients, or units of service. Indications point toward a rule of thumb of as much as two-thirds to 1 square foot per annual outpatient visit. However, space requirements can be determined only on the basis of such planning factors as scope of contemplated program; utilization of each clinical, adjunct, and administrative unit to be included in the facility; and estimates of future needs. The latter is of particular importance because of the current trends which reflect a continued acceleration in the utilization of all outpatient services. What might be considered as adequate space today will probably be considered as inadequate in the very near future. This is especially true of the Emergency Services Unit where utilization has increased by more than 112 percent in the last decade.

Layout

The layout and assignment of physical space will vary in requirements, depending upon size, complexity, and function of the particular hospital. Specialized areas for diagnostic, therapeutic, and administrative activities are being designed to afford maximum utilization by anticipated patient demands.

Planners of outpatient facilities are giving attention to such physical arrangements as patient flow patterns, sufficient waiting areas, entranceways, design of emergency areas to accommodate increased and varied medical problems, well-designed areas for filing and storage of medical records, and various other rooms for special and particular clinical work.

[3] "Financing Hospital Care in the United States, Factors Affecting the Costs of Hospital Care." Edited by Hayes, John H. 1:124–130. The Blakiston Co., Inc., New York, Toronto, 1954.

[4] Hospital Rates, 1959, American Hospital Association, Chicago, 11, Ill., 1960.

Mechanical Equipment for Environmental Control

In modern outpatient facilities, certain mechanical equipment is both desirable and necessary. Provisions are being made for the installation of systems for adequate ventilation, heating, lighting, communications between patients and nurses and other personnel, and records transportation.

These and other physical features of facilities for outpatient services are the basis for current Public Health Service studies. The results of these studies will be discussed in future publications, together with suggested standards and methods to satisfy predetermined medical and administrative needs.

U.S. GOVERNMENT PRINTING OFFICE: 1964 O—725-730

Clinic:

H. MEDICAL PROCEDURES—Continued

5. EQUIPMENT AVAILABLE IN THIS CLINIC FOR THIS CLINIC'S USE

Common types of medical equipment (check)

__Applicators
__Examining gowns
__Examining lamp
__Examining table
__Flashlight
__Hypodermic tray
__Ophthalmoscope
__Otoscope
__Percussion hammer
__Rubber gloves
__Scales
__Sphygmomanometer
__Sterile supplies
__Stethoscope
__Stock medications
__Stock solutions
__Thermometer tray
__Throat sticks
__Tuning fork
__X-ray viewer

Emergency equipment

__Cardiac kit

Other medical equipment

Form B

Terms and Definitions

(See Chapter II, Step 5)

Contents

Clinic_____
Observer_____
Observation date(s)
/ / Informant:
/ /

TERMS AND DEFINITIONS

Common Terms and Their Alternative Definitions as Used by Clinic Personnel

TERM	Used: Same (check)	Used: Synonym (enter)	Not used (check)	DEFINITION(S)	Used (check one): Same	Used (check one): Different	REMARKS
A. PATIENT							
1. OPD PATIENT Are hospital employees treated in this clinic? __Yes __No If yes (check one): __Employee status alone automatically establishes eligibility. __Employee must be screened by OPD admission procedure to determine whether he meets OPD eligibility standards. (See definition of "Employee," item A-9, p. 31)				a. Any user of the OPD services who goes through the formal OPD admission procedure and is accepted as eligible for medical care. b. Any user of the OPD services, regardless of the procedure or formality by which he gets to use them. (Includes, among all others, an inpatient seen without going through a formal admission procedure, a private patient seen casually or informally, etc.)			
2. PRIVATE OPD PATIENT				a. Anyone who is treated, under a personal arrangement, by his own private doctor in the OPD, using any or all of its services. He does not go through the formal OPD admission procedure. He may or may not pay clinic fees, but he is subject to being billed privately by his private doctor. b. Anyone who, through arrangements made by his own private doctor, uses the OPD auxiliary services for a specific diagnostic or therapeutic purpose. (See definition of "Auxiliary Service Visit," item C-2, p. 33.) He is not required to go through the formal OPD admission procedure, nor does he pay a clinic fee. However, he pays the established fee for the given auxiliary service.			

TERM	Used		Not used (check)	DEFINITION(S)	Used (check one)		REMARKS
	Same (check)	Synonym (enter)			Same	Different	
A. PATIENT—Continued							
3. NEW OPD PATIENT				a. Patient who has never before attended any clinic in the OPD. b. Patient who has never before attended any clinic or auxiliary service* in the OPD. c. Patient who has not attended any clinic in the OPD within a specified time period.† d. Patient who has not attended any clinic or auxiliary service in the OPD within a specified time period.†			
4. OLD OPD PATIENT				Reverse of "New OPD Patient."			
5. NEW CLINIC PATIENT (or NEW AUXILIARY SERVICE PATIENT)				a. Patient who has never before attended a particular clinic (or auxiliary service). b. Patient who has not attended a particular clinic (or auxiliary service) within a specified time period.† c. Patient who has previously attended a particular clinic (or auxiliary service), but is now returning with a new illness or condition.			
6. OLD CLINIC PATIENT				Reverse of "New Clinic Patient."			
7. ACTIVE PATIENT Do you think of this term as relating to: __The particular clinic (or auxiliary service)? __The OPD as a whole? __Both?				a. Patient who is attending a clinic (or auxiliary service) on a continuing basis, with an appointment being made at the close of each visit for his next visit. b. Patient who returns to a clinic (or auxiliary service) periodically, with or without appointments being made for subsequent visits. c. Patient who has used a clinic (or auxiliary service) within a specified time period.†			
8. INACTIVE PATIENT				Reverse of "Active Patient."			
9. EMPLOYEE				a. Any person who is officially referred by the Health Service (the hospital's medical facility for its staff). b. Any person on the hospital payroll. c. Any person on the hospital payroll, nursing students, and dietary interns. d. Any person on the hospital payroll and any full-time student at the hospital. e. Any person on the hospital payroll and any full-time or part-time student at the hospital.			

*Auxiliary service denotes Laboratory, X-ray, Nutrition Service, Social Service, etc. (See definition of "Auxiliary Service Visit," item C–2, p. 33.)

†If applicable, specify time period (e.g., current statistical year, past 5 years, etc.).

NOTE: This footnote is referenced in later pages with use of the same symbol (†).

TERM	Used		Not used (check)	DEFINITION(S)	Used (check one)		REMARKS
	Same (check)	Synonym (enter)			Same	Different	
B. APPOINTMENT							
1. APPOINTMENT				a. Advance arrangement made for a patient to be seen at a particular time at a clinic. b. Advance arrangement made for a patient to be seen at a particular time at a clinic or auxiliary service.			
2. OPEN APPOINTMENT				The understanding given to a patient told to "Return PRN" (see item D–3, p. 36).			
3. RETURN APPOINTMENT (See definition of "RETURN VISIT," item C–4, p. 34.)				a. An appointment at a clinic (or auxiliary service) which patient has previously attended, regardless of lapse of time. b. An appointment at a clinic (or auxiliary service) which patient has previously attended, within a specified time period.† c. Any appointment at a clinic (or auxiliary service) which patient has previously attended, for further treatment of the same condition. d. An appointment at a clinic (or auxiliary service) which patient has previously attended, for a patient "active" to that clinic (see item A–7, p. 31).			
4. INITIAL APPOINTMENT				Reverse of "Return Appointment."			
5. REAPPOINTMENT				a. Rescheduling of an appointment when it has been either broken or canceled. b. Rescheduling of an appointment when the visit on the original appointment was not consummated for whatever reason: patient or physician fails to appear, insufficient time to attend patient, laboratory test or X-ray results not properly produced, etc. (See item C–6, p. 34).			
6. BROKEN APPOINTMENT				a. Appointment not kept by patient, without advance notification to the OPD. b. Appointment not kept by patient or OPD, without advance notification.			
7. CANCELED APPOINTMENT				a. Appointment not kept by patient, with advance notification to the OPD. b. Appointment not kept by patient or OPD, with advance notification.			
8. MISSED APPOINTMENT				A broken or canceled appointment (see B–6 and B–7).			
9. MISSED APPOINTMENT FOLLOW-UP PROCEDURE				Any procedure used in arranging for patient to return to clinic after a missed appointment.			

†See footnote on p. 31.

TERM	Used (check one): Same	Used (check one): Synonym (enter)	Not used (check)	DEFINITION(S)	Used (check one): Same	Used (check one): Different	REMARKS
C. VISIT							
1. CLINIC VISIT‡ When, during one trip to the OPD, the patient attends several clinics (and/or auxiliary services): __Each such attendance is counted as a separate visit (i.e., multiple visits are counted for same trip). __The total attendance at these several clinics is counted as one visit.				a. Occasion of medical care rendered to a patient in any clinic of the OPD. b. Occasion of medical care rendered to a patient by a physician in any clinic of the OPD. c. Occasion of medical care rendered to a patient by a physician or nurse in any clinic of the OPD. d. Occasion of service rendered to a patient in any clinic or by any auxiliary service of the OPD.			
2. AUXILIARY SERVICE VISIT				Service rendered to a patient by any of the OPD's or hospital's departments or areas—not clinics per se—which contribute to the patient's medical care. These include Laboratory, X-ray, Nutrition Service, Social Service, Pharmacy, and Blood Bank, etc.			
3. CONSULTATION Check if applicable: __The "Consultation" itself is counted as a "Clinic Visit." __A fee is charged for the "Consultation" itself.				a. A deliberation of two or more physicians with respect to a specific problem regarding the diagnosis or treatment of a particular patient. (The deliberation may be between staff doctors, house officers, or a combination of the two. It could take place either in the requesting or the consulting physician's office, and the patient, if seen, may be seen in either physician's office. Consultation may also take place over the telephone.) The consulting physician may suggest treatment but does not assume responsibility for the patient's medical management, unless the consultation is later followed by a formal "referral" (see item D–1, p. 34). The consulting doctor's notes are written on the Clinical Notes Sheet (and are usually labeled "Consultation"). b. A deliberation as described in *a* above, but taking place between two or more people of any profession with respect to a specific problem regarding the diagnosis or treatment of a particular patient.			

‡Note in "Remarks" column any types of situations which, although fitting the applicable definition, are nevertheless not counted as "Clinic Visits," e.g.: (1) Exceptions of certain types of patients such as hospital employees, casual drop-ins, private patients, etc. (2) Exceptions of certain types of services such as only refilling a prescription, replenishing certain supplies furnished by the clinic, giving injections, weighing, etc.

TERM	Used (Same check)	Used (Synonym enter)	Not used (check)	DEFINITION(S)	Used (check one) Same	Used (check one) Different	REMARKS
C. VISIT—Continued							
4. RETURN VISIT (See definition of "RETURN APPOINTMENT," item B–3, p. 32.)				a. A visit made by a patient to a clinic (or auxiliary service) which he has previously attended, regardless of lapse of time (i.e., any visit after the first visit). b. A visit made by a patient to a clinic (or auxiliary service) which he has previously attended, within a specified time period.† c. A visit made by a patient to a clinic (or auxiliary service) which he has previously attended, for treatment of the same condition. d. A visit made by an "active" patient to a clinic (or auxiliary service) which he has previously attended (see item A–7, p. 31).			
5. INITIAL VISIT				Reverse of "Return Visit."			
6. REVISIT				A visit repeated because the preceding visit's purpose was not accomplished, e.g., physician could not see patient, or laboratory tests or X-ray results were not properly produced, etc. (See item B–5b, p. 32, excluding circumstances of broken or canceled appointments.)			
D. DISPOSITION							
1. REFERRAL				a. Formal advance arrangement made at the request of a clinic for a patient to be seen in another clinic, with the former clinic relinquishing control over the patient's medical management, either temporarily or permanently (depending upon the treatment advised). b. Formal advance arrangement made at the request of a clinic for a patient to be seen in another clinic, with the former clinic retaining control over the patient's medical management. c. Formal advance arrangement made at the request of a clinic for a patient to receive continued care from an auxiliary service, which would assume responsibility for that particular area of therapy (e.g., Radiotherapy, Nutrition, and Social Services). d. Formal advance arrangement made at the request of a clinic for a patient to receive medical service from an organized resource outside the hospital, but with the clinic maintaining responsibility for the patient's medical management (e.g., Visiting Nurse As-			

†See footnote on page 31.

TERM	Used (Same check)	Used (Synonym enter)	Not used (check)	DEFINITION(S)	Used (check one) Same	Used (check one) Different	REMARKS
D. DISPOSITION—Continued							
1. REFERRAL—Continued				sociation, special diagnostic procedure performed at another medical facility). e. Formal advance arrangement made at the request of a clinic for a patient to receive medical care from an organized resource outside the hospital, with the clinic relinquishing responsibility for the patient's medical management (e.g., transferring patient to a chronic disease hospital). f. Formal advance arrangement made at request of one of the hospital's units or services other than OPD (e.g., inpatient service, emergency unit) for a patient sent from that service to be followed in a clinic, with the referring unit or service relinquishing responsibility for the patient's medical management. g. Formal advance arrangement made at the request of one of the hospital's units or services other than the OPD (e.g., the inpatient service, emergency unit) for a patient sent from that service to be treated in a clinic, but with the referring unit or service retaining responsibility for the patient's medical management. h. Formal advance arrangement made at the request of one of the hospital's units or services other than the OPD (e.g., the inpatient service, emergency unit) for a patient sent from that service to be followed in an auxiliary service which would assume responsibility for that particular area of therapy (e.g., Radiotherapy, Nutrition Service, Social Service). i. Informal recommendation made by a clinic staff member to a patient, suggesting that he go to another resource (either inside or outside the hospital) for medical care (e.g., the hospital's emergency unit, private physician). j. Formal arrangement made by an outside resource, directing the patient to the clinic (or to the OPD) for medical care, with the clinic accepting responsibility for the patient's medical management (e.g., referred by a public health screening clinic, private physician).			

TERM	Used		Not used (check)	DEFINITION(S)	Used (check one)		REMARKS
	Same (check)	Synonym (enter)			Same	Different	
D. DISPOSITION—Continued							
1. REFERRAL—Continued				k. Formal arrangement made by an outside resource, directing the patient to the clinic for medical service, with the outside resource retaining responsibility for the patient's medical management (e.g., private physician, another OPD). l Outside resources suggesting informally to patient that he come to the OPD for medical service (e.g., referred by a private physician, other health facility, friend).			
2 RE-REFERRAL				A referral of a patient to a facility which he has used in the past, on referral from the same source, with the prior incident having since been closed.			
3 RETURN PRN (or PRN RETURN)				Patient is not given a return appointment to a given clinic (or auxiliary service) but is told that if his condition should recur he may call for an appointment, and "Return PRN" is written in his medical record. (See definition of "Open Appointment," item B-2, p. 32.)			
4. DISCHARGE				Patient is judged by physician (or auxiliary service staff) to need no further visits to a given clinic (or auxiliary service) and is recorded as "Discharged" in his medical record.			
E. CLINIC TIME PERIOD							
1. CLINIC SESSION				a. The total period of time during which a particular clinic meets on any given day. b. The morning, afternoon, or evening period of time during which a particular clinic meets on any given day. In the case of a clinic which meets more than one of these times on the same day (e.g., both morning and afternoon), each such period is identified as a "session."			
2 SHIFT				a. The morning, afternoon, or evening period of time during which a particular clinic meets on any given day. In the case of a clinic which meets more than one of these times on the same day (e.g., both morning and afternoon), each such period is identified as a "shift." b. A subdivision of a particular clinic's session into portions of time identified by staff-coverage changes or by the grouping of patients' appointments into "blocks" of time.			

Sample of a "Clinic Observation Guide"

Exhibit X: CLINIC PROCEDURES

Exhibit Y: RECORDS

A case illustration taken from Beth Israel Hospital, Boston, Mass.

Exhibit X

Clinic Observation Guide: CLINIC PROCEDURES

A case illustration representing procedures of the Beth Israel Hospital, Boston, Mass. These procedures are presented here only in skeletal form, to suggest the range and possible organization of subject matter which might be included in this kind of procedure description. While it has not been necessary to retain the original detail throughout (dots show where material has been omitted), section II is given more fully to illustrate the character and extent of detail which might be included.

Contents

Clinic Observation Guide

CLINIC PROCEDURES

Clinic_____

Observer_____

Observation date(s)

/ / Informant:

/ /

Working Model*	Notes on observed clinic's procedures (describe departures from Working Model)

I. PATIENT APPOINTMENT SYSTEM

Appointments are arranged at the Appointment Desk, where the Appointment Books† are kept except when they are taken to the respective clinics during clinic sessions. During the sessions, appointments are arranged directly by the clinic.

A. SCHEDULING PATIENT APPOINTMENTS

1. Appointments initiated by patient
   a. Patient requests appointment by telephone, mail or in person
   b. Appointment Desk clerk or clinic personnel‡ determines an available appointment time and—
      (1) Records appointment in Appointment Book
      (2) Informs patient of appointment time, if talking directly to him
      (3) Prepares Yellow Appointment Slip
2. Appointments initiated by clinic . . .
3. Appointments initiated by Inpatient Service or Emergency Unit . . .

B. "SQUEEZING IN" EXTRA PATIENTS

1. On scheduled basis—Clinic personnel arranges in advance by forcing in an extra appointment . . .
2. Walk-ins—Patient without appointment comes to clinic wishing to be seen at current session . . .

C. CANCELING APPOINTMENTS (for current or future sessions)

1. Cancelation on patient's initiative . . .
2. Cancelation on OPD's initiative (e.g., if doctor unable to attend that particular clinic session, or if clinic session has too many patients scheduled) . . .

II. PREPARATION FOR CLINIC SESSION

A. IN ADVANCE OF CLINIC SESSION

1. Medical Charts

   a. Appointment Desk clerk orders patient charts (includes loose inpatient and emergency unit records) for clinic from Record Room, via Record Request List made up from Appointment Sheet

   or

   b. Clinic personnel prepares its own Record Request List . . .

Check:

___

___

*This description is based on procedures observed in the prototype clinic and several other "typical" clinics (see chapter II, step 3). It is only a working model—provision is made at the right for inserting such additions, deletions, and modifications as will represent the procedures used in any individual clinic.

†Underlined terms represent items which are described in the working model of "Records" (see exhibit Y).

‡The term "clinic personnel" is used to designate any or all of the people staffing the clinic—nurse, nursing aide, secretary, volunteer, and doctor. If a particular task is the responsibility of only one of these, that person is designated rather than "clinic personnel" generally.

Working Model	Notes on observed clinic's procedures (describe departures from Working Model)

II. PREPARATION FOR CLINIC SESSION—Continued

2. Tickler Cards
   a. Nurse checks Tickler Cards flagged for the given day, for things that need to be done for certain patients on this day (patient may or may not be attending clinic on this particular day). The cards in the file alert the nurse to:
      (1) Keep track of patients who are to have specific treatments or procedures performed (e.g., injections, prothrombin time, lumbar puncture)
      (2) Schedule appointments for various diagnostic procedures (e.g., X-ray)
      . . .
      (5) Any other item needing some action — Specify:
   b. Nurse takes information or materials from Tickler Card file to clinic in one or more of the following forms (personal choice):
      (1) The Tickler Cards themselves
      (2) Information copied onto a note sheet . . .

B. WHEN CLINIC SESSION IS ABOUT TO BEGIN

1. CLINIC PERSONNEL brings the following to clinic:
   a. (Nurse) Clinic keys from Nursing Supervisor's office
   b. (Nurse) Information from Tickler Card file (see II–A–2 immediately above)
   c. Appointment Book from Appointment Desk
      (1) Appointment Sheet(s) for this session then removed from Appointment Book and placed on clinic desk
2. RECORD ROOM PERSONNEL brings the following to clinic:
   a. Medical records from the following areas, placed on clinic desk:
      (1) OPD Record Room
      (2) Inpatient Record Room—Inpatient and/or emergency unit records not yet incorporated into OPD records
      (3) Health Service—Records of current or prospective employees (a 3- x 5-inch card reading "Health Service" is attached to record cover) . . .
   b. X-ray films from Radiology Department — Are X-ray films *routinely* used at each session?
      (1) If 1 or 2 films, usually placed on clinic desk — __Yes*
      (2) If larger number of films, usually placed in film box — __No
3. CLINIC PERSONNEL takes the following work materials from clinic storage areas and prepares them for clinic session:
   a. Registration Sheet—Placed on clinic desk — Sheet shared with other clinic(s)?
      (1) Stamps clinic name and date on sheet — __Yes—Specify clinic(s):
      __No
   b. Doctors' Sign-in Sheet—Placed on clinic desk — Sheet shared with other clinic(s)?
      (1) Stamps clinic name and date on sheet — __Yes—Specify clinic(s):
      (2) Leaves name section blank for doctors to fill in as they arrive in clinic *or* — __No
      (3) Fills in doctors' names after they arrive in clinic
   c. Diagnostic Card File—Pulls cards for patients attending this session and places them on clinic desk — Does clinic have a Diagnostic Card File?
      . . . — __Yes
   e. Medical supplies and equipment—Placed in examining rooms — __No
      . . .

*OPD Record Room is responsible for ordering and delivering X-ray films to these clinics as a regular routine (one clerk is assigned this job). Record Room keeps an X-ray Book (listing patients who have X-rays) for clinics which are the most frequent users of X-rays (GI, GU, Orthopedic, Surgical, Thoracic, and Tumor). After pulling records for these clinics, the clerk either checks the patient charts or the X-ray Book to see which patients have X-rays; she then orders all films from Radiology Department the day before clinic meets. Other clinics needing X-rays either call Radiology or Record Room requesting same, and Record Room delivers.

[*NOTE: Footnotes may be used to explain certain procedures of other units of the OPD in a way which makes the description of the clinic procedures more meaningful.*]

Working Model	Notes on observed clinic's procedures (describe departures from Working Model)

III. CHART PREPARATION AND PATIENT REGISTRATION*

A. PRELIMINARY CHART PREPARATION

1. Clinic personnel checks patient charts into clinic . .

Are X-ray films checked into clinic?
__Yes
__No

2. Clinic personnel orders missing charts .

3. Clinic personnel checks charts for readiness of Clinical Continuation Sheets and adds new sheets as necessary . . .

4. Clinic personnel paper-clips Diagnostic Cards, if used, to tops of chart covers

5. Clinic nurse checks charts for completeness of medical information, including:
. . .

9. Clinic personnel awaits patients' arrival in clinic

B. PATIENT REGISTRATION

1. Patient comes to clinic desk to register and presents the following documents: . . .

2. If patient with a scheduled appointment arrives in clinic without appointment slip (patient lost or forgot slip or made appointment by telephone): . . .

3. Clinic personnel receives above materials from patient and processes them as follows: . . .

4. Clinic personnel registers each patient on Registration Sheet . . .

5. Clinic personnel disposes of registration materials in the following manner: . . .

6. Clinic personnel indicates patient's arrival in clinic by drawing a line through his name on Appointment Sheet (done at convenience of clinic personnel, either immediately following registration procedure or some time during clinic session)

7. Clinic personnel lists patient's name on Clinic Work Sheet

C. FINAL CHART PREPARATION
Completed after patient registration

1. Patients who have an OPD record: . . .

2. Patients who do not have an OPD record: . . .

3. If test results have not been located, clinic personnel asks patient if he had test(s) performed . . .

*Chart preparation is divided into two sections, Preliminary and Final: (1) Preliminary Chart Preparation is that processing of patients' medical charts usually done prior to patients' registration in clinic. The preliminary preparation includes checking charts into clinic, checking for completeness of medical information, etc. (2) Final Chart Preparation is that processing of the charts done after the patient registers in clinic. It includes stamping record sheets, recording weights, etc. (Patient Registration has been inserted between Preliminary and Final Chart Preparation to present the procedures in the sequential order in which they occur in most clinics.)

Working Model	Notes on observed clinic's procedures (describe departures from Working Model)

III. CHART PREPARATION AND PATIENT REGISTRATION—Continued

4. Clinic personnel has the following diagnostic procedures performed before patient sees doctor, and records the test results onto the documents indicated: . . .

5. Clinic personnel then indicates that both patient and chart are ready for doctor by making a red check to left of patient's name on Registration Sheet

6. Clinic personnel stacks charts where they are available to doctors, in the following order: . . .

IV. PATIENT TREATMENT

A. PERSONNEL-PATIENT CONTACT

1. Doctor-patient contact
   a. Doctor picks up, from clinic desk, chart of patient to be treated by him
   b. Doctor calls patient by name and conducts him into examining room
   c. Doctor and patient have conference
   d. If doctor wants a consultation— . . .
   e. Doctor completes write-up of patient examination, including—
   . . .
   j. Doctor returns patient's chart to clinic desk and calls next patient
2. Nurse-patient contact
   a. Procedures, tests and treatments
      (1) Nurse takes patient into examining room (may take his chart with her or may leave it at clinic desk)
      (2) Nurse performs treatment, test or procedure (e.g., gives injection, obtains specimen, or changes dressing) . . .
3. Other personnel-patient contact in clinic . . .

B. EXECUTION OF DOCTOR'S ORDERS

After doctor sees patient, he completes his notations in the patient's chart and returns it to clinic desk. Clinic personnel reviews notes and executes orders before patient is dismissed from clinic. These orders include:

1. Medical procedures to be performed in clinic . . .

Operative permit necessary?
__Yes—Specify procedure(s):
__No

2. Arranging for medical procedures to be performed outside clinic . . .

3. Arranging for prostheses* . . .

4. Posting of doctor's orders—Clinic personnel posts doctor's orders, after they have been executed, by one of following methods (personal choice): . . .

*Very few prostheses are supplied by the hospital; most are purchased from outside vendors, payment arrangements being made between patient or third party and vendor.

Working Model	Notes on observed clinic's procedures (describe departures from Working Model)

V. PATIENT DISMISSAL

A. RETURN AND REFERRAL PLANS

1. Discharge—Clinic personnel tells patient that he needs no further treatment and is discharged from clinic

2. Return PRN . . .

3. Return appointment to this clinic . . .

4. Referrals to other clinics or auxiliary services . . .

5. Referrals to community agencies . . .

6. Admission to hospital . . .

B. OTHER RELATED DUTIES

1. Medical abstracts . . .

2. Completion of forms for patients—Includes forms from insurance companies, nursing homes, rehabilitation centers, family service agencies, miscellaneous forms . . .

3. Completion of Registration Sheet and Clinical Continuation Sheet—Done as each patient is dismissed from clinic . . .

VI. FOLLOW-UP OF MISSED (BROKEN OR CANCELED) APPOINTMENTS

A. Clinic personnel identifies patients who have not kept clinic appointments . . .

B. Doctor or nurse examines the unused records . . .

C. Clinic personnel completes record of each patient not needing follow-up by stamping Clinical Continuation Sheet with clinic name, date and "No Follow-up Requested" stamp; sometimes also includes reason follow-up not done . . .

D. Clinic personnel prepares Follow-up Postcard for each patient needing follow-up . . .

E. If patient does not respond to Follow-up Postcard, clinic nurse tries other follow-up methods: . . .

F. If patient does not respond to these methods and doctor still wants to clinic, nurse asks the following to contact patient to of his returning to clinic: . . .

Does clinic follow up patients who missed appointments?

__Yes

__No (skip to Section VII, "End-of-Clinic Duties")

Working Model	Notes on observed clinic's procedures (describe departures from Working Model)

VII. END-OF-CLINIC DUTIES

A. Clinic personnel, after patients have been seen and dismissed, performs necessary functions to close clinic. This includes completion and disposition of patient charts and other records, and leaving clinic in good order 1. Clinic personnel straightens up clinic by— . . . B. Clinic personnel completes the following forms· . . . C. Clinic personnel disposes of the following items in the following ways: . . .	

VIII. UNIQUE PROCEDURES

Describe procedures which do not fit into any of the preceding subject areas (where possible, reference to most closely related section)

Exhibit Y

Clinic Observation Guide: RECORDS

A case illustration representing records used at the Beth Israel Hospital, Boston, Mass. These records are presented here only in skeletal form (dots show where material has been omitted), to suggest types of subject matter which might be included in this kind of description.

Contents

Clinic Observation Guide

RECORDS

Clinic _____

Observer _____

Observation date(s)

/ / Informant: _____

/ / _____

Working Model*—names and explanations	Check if used	Notes on observed clinic's records (describe departures from Working Model)
A. RECORDS WHICH GO INTO PATIENTS' MEDICAL CHARTS†		
1. Admission Slip. Used by admitting officer during patient's admitting interview (upon his first visit to OPD) to record social and financial history. Information is used to determine patient's clinic eligibility and fee rates for clinic and auxiliary service use. The Admission Slip is filled out in duplicate. Original is sent to OPD Record Room for inclusion into patient's chart. Duplicate is filed in Admitting Office.	_____	
2. Applications for Nursing Homes, Chronic Hospitals and Other Health Facilities. A variety of forms used to make application for patient's admission to a health facility. Each agency supplies its own forms. Admission request is initiated by clinic doctor. His signature is required on application. Processing of application is usually handled by Social Service. If application is in duplicate, one copy is placed into patient's chart.	_____	Specify forms used:
3. Clinical Continuation Sheet. A standard clinical notes sheet used to record patient's medical history and progress. Different clinics record onto same sheet to produce a continuous medical account, each clinic stamping its name in center of sheet below previous clinic's notes. Entries are made on sheet by physicians and nursing staff after each patient visit to a clinic. These notes include physical examination and history notes, prescribed treatment, medical and nursing services given, progress notes, and results of selected diagnostic and therapeutic procedures (results of other procedures are recorded on Laboratory Data Sheets, item A–8 below) . . . Some clinics also have special sheets or stamps, described below:	_____	
a. Special Clinical Continuation Sheets. Because of special nature of medical services rendered by some clinics, specially prepared sheets are used instead of the Clinical Continuation Sheets (e.g., special sheets are used in Prenatal and Physical Medicine Clinics).	_____	Specify form:
b. Special Clinical Continuation Stamps. Some clinics use a rubber stamp instead of a Special Clinical Continuation Sheet. The information outline is stamped onto the Clinical Continuation Sheet and is filled in by clinic personnel.	_____	Specify stamp:
4. Correspondence . . .	_____	
5. Emergency Unit Sheet . . .	_____	

*This description is based on records observed in the prototype clinic and several other "typical" clinics (see chapter II, step 3). It is only a working model—provision is made at the right for inserting such additions, deletions, and modifications as will represent the records used in any individual clinic.

†An OPD medical chart is made for every patient who attends the OPD (this chart contains as its nucleus, records described here in section A, items 1, 3, 6, and 8). The chart includes information bearing directly on the patient's medical problem, and information for identification and administrative purposes. Filed in the OPD Record Room, it is identified by a unit number which serves as the patient's permanent OPD number. If an OPD patient also has an inpatient and/or emergency unit record, these records are incorporated into the same folder with the OPD records, and filed in the OPD Record Room.

Working Model—names and explanations	Check if used	Notes on observed clinic's records (describe departures from Working Model)
A. RECORDS WHICH GO INTO PATIENTS' MEDICAL CHARTS—Continued		
6. Face Sheet. Made out in OPD Admitting Office at time of patient's admission interview, from identifying information on Admission Slip (see item 1 above). Face Sheets for employees are prepared in Health Service (unless employee has previously been through Admitting Office). All Face Sheets are sent to OPD Record Room for inclusion into patient's chart. The Face Sheet serves three purposes, being the means by which (1) patient is assigned an OPD number by Admitting Office, (2) basic identifying information about patient is recorded, and (3) patient's monthly use of various clinics is evidenced (clinic name and date are stamped onto sheet for patient's first visit to each clinic each month).		
7. Inpatient Record . . .		
8. Laboratory Data Sheets . . .		
9. Massachusetts Department of Public Health Forms. A variety of forms supplied by Mass. Dept. of Public Health, used by clinics either (1) to order tests which are performed by the State (e.g., serologies), or (2) to make reports to the State about patients with selected medical conditions (e.g., venereal diseases, legal blindness).		Specify forms used:
10. Social Service Notes. Notes prepared by Social Service Department regarding its contacts with patients. Two kinds of sheets are used:		
a. Social Service Face Sheet. Contains identifying information about patient.		
b. Social Service Notes Sheet. Contains a continuing summary (handwritten or typed) of contact between social worker and patient (and his family, physician, etc.). (NOTE: A new system is being tentatively introduced whereby social worker writes her summary notes directly onto Clinical Continuation Sheet within chronological sequence of patient's clinic visits.)		
11. Test Requisitions. (For ease in referencing, all diagnostic and therapeutic Test Requisitions, together with instruction forms and test results, are included here, under two categories: laboratory tests and X-rays.)		
a. LABORATORY TESTS—A set of 11 preprinted McBee forms, used to requisition laboratory tests, identified either by type of test or by name of laboratory performing test . . .		
(1) The 11 types of requisitions are:		
(a) Bacteriology—Serology. (For serology test, also need a Massachusetts Department of Public Health Wasserman Laboratory label.)		
(b) Blood Bank. (Appointment must be made for a transfusion; need a Blue Identification Label for all specimens.)		
(c) Basal Metabolic Rate (BMR). (Appointment must be made; test instruction forms given to patient.)		
. . .		
(f) Clinical Laboratory—Hematology.		
. . .		
(j) Pathology—Cytology.		
. . .		
(2) Procedure for having test performed: . . .		
(3) Processing of requisition: . . .		
b. X-RAYS		
(1) Diagnostic . . .		
(2) Therapeutic . . .		

Working Model—names and explanations	Check if used	Notes on observed clinic's records (describe departures from Working Model)
B. RECORDS WHICH DO NOT GO INTO PATIENTS' MEDICAL CHARTS		
1. Appointment Book. Two kinds of appointment books are used:		
a. Clinic. A looseleaf notebook used to store Appointment Sheets (see item 2 below). Ordinarily, each clinic has a separate book, but some clinics share books. Book is kept in clinic during clinic session and at Appointment Desk at all other times.	_____	Is book shared? __Yes—Specify clinic(s): __No
b. Diagnostic Procedures. Appointment books (their form varies) used for booking selected diagnostic procedures (e.g., intravenous pyelograms, audiograms). A separate book is used for each procedure and is kept in the clinic which is responsible for scheduling all appointments for the given procedure.	_____	Specify diagnostic procedure(s):
2. Appointment Sheets. A looseleaf preprinted sheet used for recording appointments to a clinic session. Format of sheet is adapted to each clinic's particular needs (e.g., according to its type of appointment system, need of space for injection write-ins). Majority of clinics have individual appointment sheets, but some clinics sharing common space and meeting time also share appointment sheets . . . Appointment Sheets are used by Appointment Desk clerk or clinic personnel to make up request lists for patient charts needed for clinic sessions.	_____	Is sheet shared? __Yes—Specify clinic(s): __No
3. Appointment Slip. Given to patient by personnel arranging appointment as proof and reminder of his clinic or auxiliary service appointment. It must be presented by patient upon registering at Cashier and/or at clinic. There are three types of appointment slips, each with a distinct purpose and identified by a different color: Yellow—Basic appointment slip, used for initial appointment in OPD (non-referrals), and by any clinic for return appointment to same clinic.	_____	
Blue—Used for appointment when patient is referred from one clinic to another clinic and/or auxiliary service.	_____	
Pink—Used for appointment when patient is referred to OPD by Inpatient Service and/or Emergency Unit . . .	_____	
4. Cashier's Receipt . . .	_____	
5. Diagnostic Card File . . .	_____	
6. Doctors' Sign-in Sheet . . .	_____	
7. Follow-up Postcard. Most common method of following patients who do not keep their clinic appointments . . .	_____	
8. Inpatient Admission Card . . .	_____	
9. Miscellaneous Charge Ticket. A duplicate McBee requisition form used by clinic personnel to charge patients for various procedures and/or materials given to them during clinic session . . .	_____	
10. Prescription Forms . . .	_____	
11. Prosthetic Order Form . . .	_____	
12. OPD Identification Card . . .	_____	
13. Record Request List . . .	_____	
14. Reference Materials. A variety of literature available in clinic and used for reference purposes by clinic staff (e.g., Dietary Manual, Formulary, Clinic Stock Charge List, X-ray Charge Sheet).	_____	
15. Registration Sheet . . .	_____	
16. Tickler Cards. 3- x 5-inch index cards kept in a file in OPD Nursing Supervisor's office. These serve as reminders to the nurses for things which will need to be done at some future date for clinic patients . . .	_____	

C. ADDITIONAL RECORDS, UNIQUE TO THIS CLINIC (list and describe)

RECORDS WHICH GO INTO PATIENTS' MEDICAL CHARTS	RECORDS WHICH DO NOT GO INTO PATIENTS' MEDICAL CHARTS

U S GOVERNMENT PRINTING OFFICE : 1984 O—706-238

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